The program has gained acceptance from physicians and other obstetric providers. As of January 1, 1997 there are 151 (up from 144 last year) Medicaid-certified prenatal care coordination service providers. Almost 96 percent of Wisconsin's 72 counties have at least one Medicaid-certified prenatal care coordination provider and all of Wisconsin's tribal agencies have obtained Medicaid certification to provide the benefit.

1995 Wisconsin Act 303 added $2.8 million to the Medicaid budget to provide case management services to Milwaukee County children at risk for poor health outcomes. Among the goals of the benefit are higher immunization rates, more routine health screens, and fewer referrals to child protective services.

The goal of this 1995 legislative enhancement to prenatal care coordination is to reach as many families as possible. To date, 282 families have received this enhanced child coordination benefit.

B. Annual Report to the Joint Committee on Finance on Access to Care and Reimbursement Rates of Obstetrical and Pediatric Services.

Section 101 of Wisconsin Act 336 (the 1990 Wisconsin Annual Agency Budget Adjustment Act) created Section 49.45(2)(a)21 of the statutes which requires the Medicaid program to "submit a report by October 1, 1990 and annually thereafter on access to obstetric and pediatric services under the medical assistance program, including the effect of medical assistance reimbursement rates." The Joint Committee on Finance is the bipartisan committee, made up of members of both houses, which reviews all appropriations and taxation measures before the legislature. The seventh annual report will be submitted to the Joint Committee on October 1, 1997.

C. Primary Care Expansion by FQHCs

The 100% cost-based reimbursement to twenty-four (24) Federally Qualified Health Centers (FQHCs) in Wisconsin, five (5) of which are located in the city of Milwaukee has helped to support the expansion of primary care services to a pediatric and obstetric population. In addition, seven tribal FQHCs have sought Medicaid reimbursement and two others will seek reimbursement in the next fiscal year. These centers have used these funds to hire primary care providers who will provide pediatric or obstetric services, or both. In addition, funds have been used to add new exam rooms at most sites to accommodate the increase in patients served.

D. Rural Health Clinics

Rural Health Clinic (RHC) certification, like FQHC designation, is intended to increase the availability and accessibility of primary care services for residents of underserved communities. It provides cost-based reimbursement to certain providers in underserved rural areas. This certification supports the use of non-physician providers and may help primary care clinics operate in communities where they might not otherwise be financially viable.

As of January 1997, Wisconsin had forty eight (48) rural health clinic sites, up from thirty-six (36) in the previous year. The number of rural health clinics has more than tripled over the past three years, as providers seek more viable ways to sustain services in underserved rural communities.

E. Targeted Case Management

Targeted case management is Wisconsin Medicaid's program for helping recipients gain access to needed medical, social, vocational and rehabilitative services. The 1995-97 biennial budget allowed expanded target populations, with special emphasis on services to children. These programs became operational in January 1996. New populations include: children at risk of physical, mental or emotional dysfunction; children with asthma; and children in the Birth to Three program, which focuses on children with physical disabilities. Previously, targeted case management was aimed only at children with developmental disabilities.

F. Presumptive Eligibility

The Presumptive Eligibility (PE)Program has operated in Wisconsin since 1987. This program entitles pregnant women to Medicaid-covered ambulatory prenatal care services, including prenatal care coordination and dental services. Presumptive eligibility enables women to obtain early prenatal care prior to a formal determination of eligibility for Medicaid.

The period of presumptive eligibility begins the day on which a provider medically verifies the pregnancy and determines, based on preliminary income information, that a woman's family income does not exceed 185% of the poverty level. The presumptively eligible woman must receive a formal determination of eligibility by the end of the month following the month in which PE was allowed.

Approximately 500 women per year receive PE; more than 90% of whom ultimately become formally eligible. Wisconsin spends about $900,000 annually on this PE benefit.

G. High Cost Case Management

High Cost Case Management (HCCM) is a new program that will provide case management services to pediatric and adult Medicaid recipients with high-cost chronic conditions (i.e., annual medical expense greater than $25,000). This includes children and adults who are ventilator-dependent or have other high-cost medical conditions.

HCCM's objectives are to improve the quality of care provided to this population and save tax dollars through improved case management. As the Department moves toward revision of the state's long term care services programs, these case management efforts will offer an opportunity to learn more about the needs of this high-cost population.

Assurance of HMO Obstetrical and Pediatric Services - Contract Activities

The Department assures that the Wisconsin Medical Assistance Program's 1903(m) (HMO) contract rate-setting activities are consistent with and substantiated by the data submitted in the State Plan Amendments concerning these services. The assurances are based on funding allocated in 1990 Wisconsin Acts 336 and 351, 1991 Acts 39 and 269, and 1993 Act 16.

I. Fee for Service Reimbursement for Pediatric and Obstetric Services

As described above, the Department establishes maximum reimbursement rates for pediatric practitioner and obstetrical practitioner services to assure that these services are available to Medicaid recipients at least to the extent that such services are available to the general population in the geographic area.

A. Pediatric Practitioner Services

Listed in Appendix 4-PED are the Medicaid program maximum fee-for-service reimbursement rates for pediatric services provided by physicians to children 18 years-of-age and under which were effective for dates of service on and after July 1, 1997. It does not include any possible rate increases that may occur if the Governor's current budget request or other legislation is approved by the Legislature. Maximum reimbursement rates for the same services performed by certified nurse practitioners are the same as for physicians.

B. Obstetrical Practitioner Services

Listed in Appendix 4-OB are the maximum fee-for-service reimbursement rates for obstetrical services provided by physicians effective for dates of service on and after July 1, 1997.

Reimbursement for certified nurse midwives is made as a percentage of the supervising physician's payment. Specifically, payment is made at the lesser of the usual and customary charge or 90% of the physician's maximum allowable fee for that procedure.

Maximum reimbursement rates for obstetrical services performed by certified nurse practitioners are the same as for physicians.

II. HMO Reimbursement Rates for Obstetrical and Pediatric Services

A. Introduction

As of January 1997, 163,078 Medicaid recipients were enrolled in HMOs in 40 counties across the state.

This is a result of the 1995-97 biennial budget, which mandates statewide expansion of managed care for AFDC recipients in areas where HMOs indicate a willingness and ability to provide services. Wisconsin anticipates that, based on responses from interested HMOs, that more than 230,000 recipients in all but a few northern counties in Wisconsin will be covered by managed care contracts by the end of the biennium.

Expansion is being implemented in three stages, starting with Southeastern Wisconsin and moving north and west. In designing managed care expansion, the Department required HMOs to demonstrate 20-mile service access to primary care services. Recipients outside the 20-mile access area will not be mandatorily enrolled in HMOs.

Recipients in the Medicaid HMO program have a choice of HMOs. In order for a county to be considered mandatory for HMO enrollment, two or more HMOs must participate. Once recipients have chosen an HMO, they have a choice of primary care physicians (PCP) within the HMO.

Comparison studies indicate that HMO recipients are more likely to receive required immunizations, well-child visits, and pap smears and have lower C-Section rates than their fee-for-service counterparts. Therefore, Medicaid managed care not only saves money; it also improves access to primary care services.

Wisconsin is undertaking a major quality assurance effort to better measure and improve service provided to recipients enrolled in HMOs. These efforts include: the establishment of measurable goals and objectives to be included in HMO contracts; data collection and analysis; routine and regular audits of HMOs and providers; and provider/recipient satisfaction surveys. In addition, Wisconsin routinely measures and publishes utilization data comparing managed care to fee-for-service for a number of selected services, such as immunizations, births, routine HealthCheck screens and hospitalizations for preventable diseases.

The calendar year 1996 maximum capitation rate (per person per month) for Milwaukee County HMOs: $120.19; for Dane County HMOs: $104.11; for Eau Claire County HMOs: $103.76; and for Waukesha County HMOs, $117.03. Capitation rates are based on Medicaid fee-for-service payments which were made in the HMO counties prior to the Medicaid HMO Initiative (1984). Total annual payments per county are divided by total eligible months for the county. Capitation rates for 1996 were increased by 2.2% over 1995 levels.

Attachment A describes the methodology for establishing capitation rates and lists those rates for AFDC/Healthy Start children and Healthy Start pregnant women through calendar year 1997.

B. Capitation Rate Adjustments

In CY 91 obstetric services provided by physicians (not including inpatient or outpatient hospital services) equal an average rate of $5.45 per person per month in the HMO counties or approximately 5% of the total HMO rate. Pediatric services provided by physicians (not including inpatient or outpatient hospital services) make up approximately 3.6% of the total rate or $3.92 per person per month. These estimates were based on the average amount of obstetrical and pediatric fee-for-service payments made in 1984, inflated forward to 1991 levels and discounted by 7.48 - 8.22%, and on the funding increases provided to the HMOs on January 1, 1991 and July 1, 1990.

Adjustments to the HMO capitation rate have been made for the years since 1991 to parallel the changes made in the fee-for-service program. In 1992, we added $.96 for obstetric services and $1.47 for pediatric services. The increases in 1993 included $.93 for obstetrics, $1.47 for pediatrics as well as $.22 for HPSA bonus payments (10% for primary care services provided in HPSAs or to recipients who reside in HPSAs). The 1994 capitation rates were increased $.71 for the 2% increase to all primary care providers as well as $1.27 for additional HPSA bonus payments.

Adjustments to the 1995, 1996 and 1997 rates are summarized in the table below. The adjustments include those made for primary care, HPSA bonuses, pediatric dental, vaccine administration and physician assistants/nurse midwives. Pediatric dental and HPSA adjustments were made in each of these three years. The other adjustments were made only in 1995.

HMO Capitation Adjustments
1995-1997

Year	2% Primary Care	HPSA Bonus	Pediatric Dental	Vaccine Administration	Physician Assistant/Nurse Midwives
1995	$0.91	$2.60	$0.21	$0.03	$0.01
1996		$2.06	$0.79		
1997		$2.06	$0.79		

ATTACHMENT A

METHODOLOGY FOR ESTABLISHING HMO CAPITATION RATES

The Wisconsin Medicaid HMO program was operational in five urban counties prior to statewide expansion. The pre-expansion HMO counties include Dane, Eau Claire, Kenosha, Milwaukee and Waukesha Counties. Capitation rates in the HMO counties are county-specific and based on a comparison of pre and post-HMO fee-for-service (FFS) payments for the HMO counties.

Since actual FFS cost data for HMO eligibles do not exist in current HMO counties, the Medicaid program collects FFS cost and eligible month data from eight control counties. (The control counties were selected by our contracted actuary, Milliman and Robertson, Inc.) An average per member per month cost (or composite FFS equivalent) is calculated for the control counties and inflated from the cost year to the rate year. (CY 1995 cost data were used to calculate the FFS equivalent for CY 1997.) The FFS equivalent is also adjusted for budgeted program initiatives which are not reflected in the cost data. The resulting FFS equivalent is then compared to the FFS equivalents from the last year actual FFS data was available in the HMO counties.

This method, which was developed by Milliman and Robertson, assumes that HMO counties would have experienced the same rate of growth in FFS costs as the eight control counties. Milliman and Robertson also calculate the inflation adjustment factor based on an analysis of actual Medicaid expenditures over the past several years. Based on the resulting 1997 FFS equivalent, a decision was made to maintain CY 1997 capitation rates at the 1996 levels for each HMO county.

The same rate-setting method was used to calculate the FFS equivalents for the HMO expansion areas with one exception - the rates are not county-specific. The HMO expansion area was divided into nine rate regions. A composite FFS equivalent was developed for each of the nine rate regions, adjusted for inflation and relevant program initiatives and discounted accordingly. However, the resulting rates revealed severe disparities and variances between rate regions.

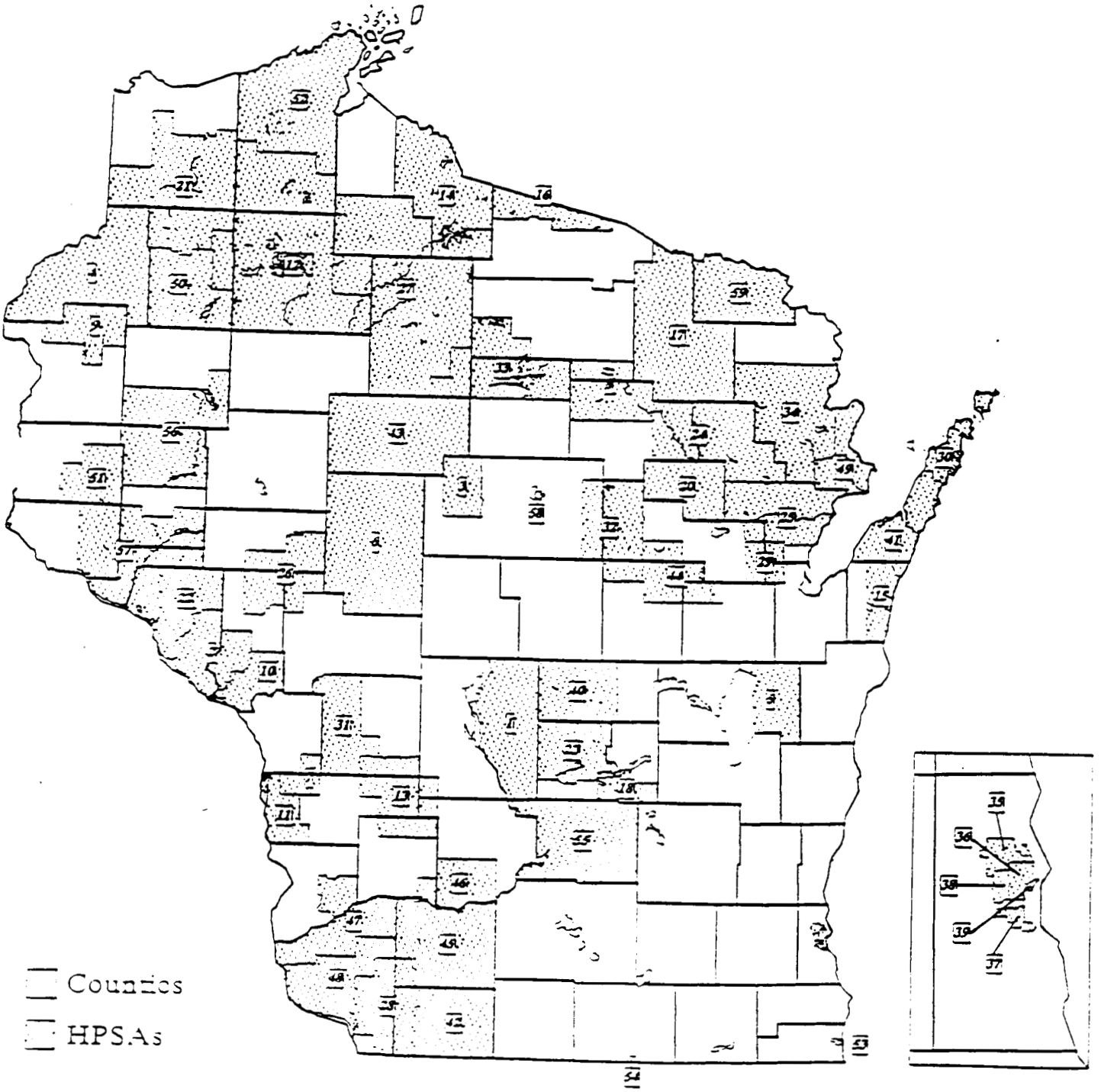
Recognizing that an across-the-board discount to the regional FFS equivalent would have continued historical inequities existing in the rural areas of the state, a final adjustment to the FFS equivalent was necessary. The discounted composite FFS equivalents were adjusted by raising regional capitation rates up to the discounted median rate of all counties and rate regions. This adjustment was applied to both AFDC/Healthy Start Children and Healthy Start Pregnant Women rates. Regions with capitation rates below the median for all counties and regions were brought up to the median rate. Other regions with capitation rates above the median were not affected by this adjustment. In total, seven rate regions had their respective rates adjusted to the median.

A summary of county and regional capitation rates in effect through December 31, 1997 is attached.

HMO Capitation Rates Through December 31, 1997
Assumes Dental and Chiropractic Furnished by HMO

HMO County/ Rate Region	AFDC/HS Children	HS Pregnant Women
Dane	$106.42	$478.13
Eau Claire	$106.06	$544.49
Kenosha	$114.03	$494.29
Milwaukee	$122.86	$534.87
Waukesha	$119.63	$456.07
Region 1	$105.49	$443.23
Region 2	$102.85	$443.23
Region 3	$102.85	$443.23
Region 4	$102.85	$443.23
Region 5	$102.85	$453.05
Region 6	$103.72	$443.23
Region 7	$102.85	$443.23
Region 8	$102.85	$457.10
Region 9	$102.85	$443.23

Wisconsin
Health Professional Shortage Areas
January 1996



APPENDIX 2

WISCONSIN HEALTH CARE REGIONS